

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045232

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11255

STATE FILE NUMBER

FILED NOV 22 1963

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY - - -   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo. b. COUNTY - - - |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis, Mo.                |  | c. CITY OR TOWN St. Louis   |  |
| Length of stay in lb 2 weeks   |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                     |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION St. Luke's Hospital |  | d. STREET ADDRESS (If outside, give location)<br>6253 Nottingham  |  |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                  |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                    |  |

|  |                       |   |  |
|--|-----------------------|---|--|
| 3. NAME OF DECEASED (Type or print)<br>A.K.A. Clarence H. Henry Bley Bley  |                       | 4. DATE OF DEATH<br>Month November Day 12, Year 1963  |  |
| 5. SEX<br>M  | 6. COLOR OR RACE<br>W | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br>10-22-1896                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>accountant (ret.) |                       | 10b. KIND OF BUSINESS OR INDUSTRY<br>Granite City Steel   | 11. BIRTHPLACE (City and state or country)<br>St. Louis, Mo. |
| 12. CITIZEN OF WHAT COUNTRY<br>U.S.A.  |                       |   |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 13a. FATHER'S NAME<br>Henry Bley   |  | 13b. MOTHER'S MAIDEN NAME<br>Emma Angermueller |  | 14. NAME OF HUSBAND OR WIFE<br>Eunice Bley        |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war and date of service)<br>yes |  | 16. SOCIAL SECURITY NO.<br>[redacted]          |  | 17. INFORMANT<br>Mrs. Eunice Bley 6253 Nottingham |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Generalized peritonitis<br>St. collector<br>Diverticulitis<br>Conditions, if any, which gave rise to above (b) 11-14-63<br>Cause last (c) 572.1 |  | INTERVAL BETWEEN ONSET AND DEATH<br>72 hrs<br>10 days<br>? years   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>572.1  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. Month, Day, Year  |  |   |  |  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 20f. CITY, TOWN, OR LOCATION<br>COUNTY STATE |  |
| 21. I attended the deceased from 10/22/63 to 11/12/63 and last saw him alive on 10/12                             |  |  |  |  |  |
| Death occurred at 10 48 m on the date stated above, and to the best of my knowledge, from the causes stated.      |  |  |  |  |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 22a. SIGNATURE<br>(Degree or title)<br>George B Raden M.D.     |  | 22b. ADDRESS<br>1411 857 N Kingshighway |  | 22c. DATE SIGNED<br>11/12/63                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>removal           |  | 23b. DATE<br>11-14-63                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Valhalla |  |
| 23d. LOCATION (City, town, or county)<br>St. Louis, Mo. County |  |   |  |  |  |

|   |  |                          |  |   |  |
|---|--|--------------------------|--|---|--|
| 24. FUNERAL DIRECTOR<br>HOFFMEISTER COLONIAL MORTUARY |  | ADDRESS<br>6464 Chippewa |  | 25. DATE RECD. BY LOCAL REG.<br>NOV 14 1963 |  |
| 26. REGISTRAR'S SIGNATURE<br>Loal Smith M.D.          |  |                          |  |   |  |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT

|                     |              |
|---------------------|--------------|
| VS 300<br>Rev. 4/59 | DATE AMENDED |
| 1                   |              |
| 2                   | 21/4         |
| 3                   | 2            |
| 4                   | 0            |
| 5                   | 1            |
| 6                   |              |
| 7                   | 0            |
| 8                   | 1            |
| 9                   |              |
| 10                  |              |
| 11                  |              |
| 12                  | 81-0         |
| 13                  |              |

81

*Charles: B. B. B.*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John L. Dennehy*

Licensed Embalmer No. 4194

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.